Pharmacy Services Claim Form

FIELD NAME	INSTRUCTIONS
Patient Last Name	Enter the first five letters of the recipient's last name.
First Name	Enter the first two letters of the recipient's first name.
Recipient ID Number	Enter the recipient's nine-digit Medical Assistance ID number.
Location (LOC) Code	Enter one of the following codes for the location of the recipient when the prescription was dispensed. 1 - Walk-In 2 - Nursing Facility 3 - ICF/MR
EPSDT	Enter "Y" if the drug was dispensed to a recipient under this program. Enter "N" if it was not.
OI Indicator	Enter "Y" if another insurance carrier (including Medicare) will be liable for a portion of the payment. Enter "N" if there is no other insurance.
OI Carrier	Enter the three digit carrier code of the other insurance.
Compound	Enter "Y" if the drug being billed is a compound drug (and complete the "Compounds" box in the lower-left hand corner.) Enter "N" if it is not.
Prescription Number	Enter the pharmacy-assigned tracking number of the prescription being dispensed.
Prescribing Provider Number	Enter the prescribing provider's National Provider Identifier or Medical Assistance number. If not a Medical Assistance provider, enter UPIN number or State License number.
Date Dispensed	Enter the date that the drug was dispensed to the recipient (Month/Day/Year format).

National Drug Code (NDC)	Enter the 11-digit NDC number exactly as it
Dispensed	appears on the drug package. If billing a compound drug, use 99999-9999-99.
Allowed Refills	Enter the number of refills allowed on the original prescription (between 0 and 5).
Refill Code	Enter the refill number for this prescription (0- 5).
DAW	Enter "Y" if this prescription was DAW (Dispensed As Written). Enter "N" if a generic substitution was dispensed.
Metric Quantity	Enter the quantity of the drug dispensed to the patient.
Days Supply	Enter the number of days supply of the drug that was dispensed.
Usual and Customary Charge	Enter the usual, customary and reasonable (UCR) amount charged for this drug.
Dispensing Fee	Enter the amount charged to dispense the drug.
OI Amount	Enter the amount paid by the other insurance carrier for this drug.
Charge	Enter the amount that the pharmacy is charging the Medical Assistance program for this drug, including any dispensing fee.
Compounds	For compounded prescriptions over $15.00, enter the NDC number, names, quantity and cost of all the ingredients . You may also use this space to clarify any other item on the claim. **Important: Compounded drugs over $15.00 must be billed on a paper claim.**
Total UCR	Enter the total of all the line item UCR charges (in column 18).
Total OI	Enter the total of all the other insurance amounts (in column 20) paid on this claim.

Total Charge	Enter the total of all the line item charges (in column 21) of this claim.
Pharmacy Certification	Claim must be signed and dated by the provider or an assigned representative. (No stamps or initials are acceptable.)
Provider Name	Enter the name of the pharmacy filling the prescription.
Provider Number	Enter the 10 digit National Provider Identifier or the pharmacy's seven character Medical Assistance provider number.